HEALTH RI STRATEGIC PLAN

2004 - 2010

December 16, 2003

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HEALTH RI
STRATEGIC PLAN 2004 – 2010

Strategic Planning has taken on an enhanced meaning at HEALTH in 2003. The emphasis on preparedness and the new work it brought altered our priorities. In April, we recognized that we need a full strategic planning process to deal with the challenges of public health, Zero-Based Budgeting, emergency preparedness, Fiscal Fitness and general fund reductions. Our past strategic planning efforts have been useful, but we have stopped short of completing the implementation strategies and wrestling with tough priority-setting decisions. Our strategic plan must clearly define our mission and vision and the outcomes and strategic goals to achieve them. It has to include our operating plans and activities and align our actions with the outcomes we seek.

HEALTH needs its strategic plan to describe to a wide audience what we do, why we do it, and how we do it. We also need to describe our direction and our priorities to ourselves, so we are all pulling together. Our new strategic plan focuses our resources in a strategic direction and aligns them internally to be more efficient and to face challenges ahead. Our strategic plan is an ongoing process, a work in progress. It is a dynamic plan that we use together to shape and direct HEALTH's work in order to assure that all Rhode Islanders have the opportunity to live a safe and healthy life in a safe and healthy community.

STRATEGIC PHASE

During the strategic planning phase in the spring of 2003, the Executive Committee reviewed and clarified the Mission, Vision and Outcomes of HEALTH as follows:

Mission:
Protect and promote the health of Rhode Islanders.

Vision:
All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

Outcomes:
• The burden of disease and disability in the population is reduced.

•Human environments are safe and healthy.

•All people have access to high quality health services.

•All people practice healthy behaviors.

The Executive Committee then developed a set of eight strategic goals aimed at making a significant impact on these outcomes between 2004 and 2010.

1. Develop and implement an integrated department plan by the end of 2005 that harnesses the energy, expertise, programs and partnerships of all divisions to address the over-arching goals of Healthy Rhode Islanders 2010: Eliminate Health Disparities and Increase Quality and Years of Healthy Life. Place emphasis on eight of the leading indicators: physical activity, overweight and obesity, tobacco use, responsible sexual behavior, injury and violence, environmental quality, immunization, and access to health care.

2. Achieve and maintain a coordinated departmental response capacity for public health emergencies by October 2004 and integrate with other governmental agencies and the health care sector response plans by the end of 2005.

3. Use public health data and science to guide policy and program development, implementation, evaluation and retention, and position HEALTH as the key source of public health information, and to provide easy access to high quality public health information that people want and need.

4. Develop and implement a public health agenda and plan for healthy homes and healthy communities in Rhode Island core cities by the end of 2006, and for the entire state by the end of 2008.

5. Develop and implement a public health agenda and plan for healthy human development for Rhode Island, connecting physical, educational, cultural, emotional, social, and economic environments to health outcomes by the end of 2006.

6. Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services.

7. Assess and build the capacity to provide essential public health services for the people of Rhode Island by the end of 2009**,** using National Public Health Performance Standards.

8. Engage the entire health sector and other partners in preventing and controlling infectious disease by 2005.

OPERATIONAL PHASE

The responsibility for developing the Operational Plan was delegated by the Executive Committee to two internal teams – the Business Activities and Operational Teams. These teams worked on separate aspects of the planning process until September, when they combined to form one team to complete this final product. This report is the result of the team's work to take the strategic objectives and transform them into an integrated plan - complete with objectives, action steps, measures, key internal and external partners, and time schedules.

Early in this phase of the process, the planning team members developed a brief document entitled *What Will It Take to Achieve a Successful Planning Process?* This document articulated fourteen items that were circulated to the Executive Committee and within divisions as important guidelines to which the team was committed. One of these was to create opportunities for HEALTH employees to have personal, active involvement and direct input to the operational plan. The attached planning document reflects this input.

During the operational planning phase, certain overarching issues or themes emerged repeatedly as each of the goals was discussed. It was felt that HEALTH's ability to effectively address these issues was critical to the success of the overall plan. The team decided to articulate each of the overarching

issues in this narrative, and to recommend that they become an integral part of the implementation phase.

Change Management

One of the goals of the strategic planning process is to create a road map to achieve the goals and outcomes of HEALTH. Actually implementing this road map will mean aligning and re-aligning HEALTH resources in new ways, and in some cases altering or eliminating them. We must be prepared to support HEALTH staff through this transition process. A well managed change process is critical to do this in a timely and efficient manner that maximizes resources and minimizes stress. Therefore, a continuous process of communication and dialogue with HEALTH staff on strategic activities and HEALTH's expectations of employees during the change must be implemented.

Solid efforts were have been made to involve employees in the planning process and to gain their buy-in to this plan. However, we must still be cognizant of resistance to change at all levels - front-line, middle managers, and senior managers – in the implementation phase. Successful change management will help employees understand their own natural reactions to change, and will smooth the transition from a focus on the past to a focus on the future. Change management activities should be started early in the implementation phase, instead being add-ons or afterthoughts.

Priority Setting

With any process that sets new priorities, existing HEALTH activities must be assessed for their importance to our mission and mandates. Low priority ones must be reduced or eliminated to make way for new initiatives. Since there is no expectation of any substantial increase in personnel in the plan implementation period, the plan must be sized and timed to be able to succeed without additional staff. Successful implementation of this plan will only occur if the people given responsibility to accomplish its many objectives are freed from conflicting responsibilities.

Human Resources

A key factor with respect to several of the strategic objectives and the action steps is Human Resources. In order to implement the strategic objectives, an assessment of our current HEALTH staff, their skill sets, and how employees are deployed throughout existing programs needs to occur. This will be aided by the Business Activities review, but also by analyzing other key factors.

These other factors include the FTE Cap, HEALTH's current status with respect to this cap, funding and budgetary issues, union contracts, the impact of Fiscal Fitness, training needs, any classification/compensation issues, division human resource plans, and existing statutory responsibilities and obligations.

Financial Resources

Without question, no strategic planning process can be labeled complete without an assessment of available financial resources. Sufficient funding is the linchpin of successful implementation of strategic objectives and policy decisions. However, quantity of funding is not the sole issue when discussing financial resources. We must also consider the source(s) and the time period of available funding. These issues become paramount when attempting to reallocate staff or physical resources across divisions or programs, as the funding utilized for these purposes may come with restrictions.

Communications

Employee input has been valuable in shaping our strategic plan. We must systematically engage larger numbers of our colleagues as we begin to implement the strategic plan – our outcome will be better with high levels of involvement.

Communication is essential in gaining understanding and support of all staff. We must communicate our strategic direction at all opportunities. We must move beyond words and model the behaviors that are intrinsic to our plan. We must also listen carefully to our colleagues so that we develop a shared understanding of the opportunities and the challenges inherent in the plan. Obstacles must be confronted and removed. Action is essential to empower others and to maintain the credibility of our effort as a whole.

Our commitment to communication will build trust and help our colleagues understand that the change implied in the plan is possible.

Community Involvement / External Partners

As a public agency, our customers are the people of Rhode Island. Given that there are no local health departments and that community buy-in is vital to our success, community partners are critical to the successful development and delivery of public health services.

Representatives of the populations we serve must be brought into the planning and implementation process at the earliest appropriate opportunity, recognizing that some of the goals call for specific actions internal to HEALTH.

Health Disparities

Racial and ethnic minority populations receive in general a lower quality of healthcare than the non-minority population, even when controlling for access-related factors. Moreover, although women tend to access medical care more often than men, they may not be treated with parity within health care institutions. There are other types of health disparities based on age group, household income, educational level, disability status, geographic location, and other characteristics.

Since these health disparities are very complex and rooted in historic and contemporary inequities, their elimination will require comprehensive, multi-level strategies. How effectively HEALTH works with communities and other state agencies to reduce and eliminate health disparities will determine how healthy Rhode Island will be as a state.

Cultural Competency

Given the ever changing demographic picture of Rhode Island, it is vital that HEALTH develops and implements culturally competent public health interventions. Cultural and linguistic competence implies the ability of the health care system to understand and respond effectively to the cultural and linguistic needs of its diverse population.

The DHHS has developed Recommendations for National Standards for Cultural Competence in Health Care for all recipients of federal funding. HEALTH should use these recommendations as a road map when the strategic plan is executed. Furthermore, HEALTH should assure that staff

members receive ongoing education in culturally competent service delivery, and should implement strategies to recruit and retain employees from a variety of backgrounds across all levels of the organization.

Evaluation

Evaluation is a key to all of the work that is performed in HEALTH - program and/or project evaluation mechanisms, utilizing objective measurement and systematic analysis, enabling staff to achieve their intended objectives. Evaluation allows for retrospective assessments of the work that has been done, and equips staff with the tools to make mid-course corrections as required.

This strategic plan has built-in mechanisms to evaluate our progress on an ongoing basis, including measures and completion deadlines. In addition, an annual review of the plan should be conducted to determine how well these completed steps are addressing the goals and outcomes. We believe that to specifically articulate an evaluation component for each of the objectives contained within this plan would be redundant. Evaluation is an integral part of HEALTH in all the work we do.

GOAL # 1. Develop and implement an integrated department plan by 2005 that harnesses the energy, expertise, programs and partnerships of all divisions to address the over-arching goals of Healthy Rhode Islanders HRI2010: Eliminate Health Disparities and Increase Quality and Years of Healthy Life. Place emphasis on eight of the leading indicators: physical activity, overweight and obesity, tobacco use, responsible sexual behavior, injury and violence, environmental quality, immunization, and access to health care.

Objectives	Action Steps	Measures	Internal Partners / Responsible Parties	External Departments	Other External Partners
1. Coordinate existing internal resources and increase collaboration among the divisions within HEALTH that have identified roles in the HRI2010 goals and priorities by (date).	1a.Identify all current HEALTH programs and personnel that specifically address HRI2010.	1a. Inventory of programs and personnel developed by (date).	To be assigned		To be identified as part of process to participate in Steering Team
	1b.Charge cross-divisional priority-specific workgroups of identified programs and their designated leaders to regularly exchange information, coordinate initiatives, implement collaborations, and develop new initiatives.	1b. Role and membership of teams identified by (date) 1b. Role and designation of leaders identified by (date) 1b.Regular team meetings begin by (date).	Executive Committee Workgroups		
	1c. Charge steering team of workgroup leaders and key stakeholders to oversee process, coordinate activities across programs, identify areas for collaboration and recommend organizational changes where appropriate.	1c. Key stakeholders for steering team identified by (date). 1c.Regular steering team meetings begin by (date).	To be assigned Steering Team		
2. Develop HEALTH and statewide knowledge of HRI2010 and commitment to its accomplishment by (date).	2a. Identify and train key staff from each Division who will be responsible for training all HEALTH staff.	2a. Each Division has trained trainers	Executive Committee		
	2b. Determine and provide appropriate level of training for all HEALTH employees.	2b. All employees understand the significance of HRI2010 goals and priorities (by date).	Divisional trainers		
	2c. Provide training to external partners in HRI2010.	2c. Partners have access to training opportunities (by date).	Steering Team		
	2d. Develop formal opportunities for employees from throughout HEALTH to have short-term assignments ("loaned executives") to work on HRI2010 initiatives.	2d. HRI2010 loaned executive program established (by date).	Executive Committee Workgroups Steering Team		
3. Provide new opportunities to leverage existing HEALTH resources to address HRI2010 goals and priorities by (date).	3a. Review the literature and other state health departments to identify nontraditional ways to address 2010 through existing programs.	3a Literature review completed by (date).	Steering Team		
	3b. Develop and implement a plan for existing HEALTH programs to enhance existing activities to address HRI2010.	3b. Plan completed by (date).	Steering Team Executive Committee		

Goal #2 – Achieve and maintain a coordinated departmental response capacity for public health emergencies by October 2004 and integrate with other governmental agencies and the health care sector response plans by 2005.

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments	Other External Parties
1. Establish the emergency response structure to be used by HEALTH (e.g., ICS). Train employees and others (by date).	1a. Announce structure 1b. Train staff 1c. Train others	1a.Formal announcement by November, 2003. 1b. All staff receive training in new system by April, 2004. 1c. Complete statewide ICS training per federal mandate by April, 2004.	1a.Director Ex Committee 1b. c. All programs	EMA, DEM, Governor's office, SERC	LEPC's
2. Complete department-wide Emergency Operations Plan (by date).	2a. Assign responsibility for obtaining input and completing plan to appropriate individuals/ groups. 2b. Complete detailed plans for different types of emergencies, and integrate across divisions and the system. 2b. Assign emergency health planners as resources to all divisions. 2c. Determine/finalize interpretation of HEALTH's legislative responsibility for emergencies.	2a. Finalized EOP by April, 2004 supported and approved by all divisions and key partners. 2b. Table of Contents, outline, checklist, or description of responsibilities for specific emergencies accompanies EOP by (date). 2b.Finalize emergency- and office-specific plans by (date). 2b.EOP plans reflect ICS by (date). 2c.White paper completed/ approved on HEALTHs role in radiation emergencies by (date). 2c. All those with delegated authority surveyed to ensure no outstanding issues re: EOP. 2c. HEALTH role with radiation and other emergency prepared ness issues will be included in HEALTH's annual legislative planning process by (date)..	2a. All programs 2b. All programs 2c. Occ & Rad Health Env. Health Bio-terrorism program Legal Services	EMA, DEM, Governor's office, SERC, Fire Marshal	Brown, URI, Cities/Towns, Businesses, Utilities
3. Assign accountability for leadership and system coordination of the response plan for each emergency to a specific person or group (by date).	3a. Establish criteria, responsibilities, and process to identify an appropriate Incident Commander to provide leadership and system coordination for each type of emergency.	3a. Criteria and process adopted by Jan. 2004. 3a. A qualified person or persons is/are named by HEALTH, or the appropriate lead agency, as Incident Commander for each emergency type by April, 2004.	3a. Director, Executive Committee		
4. Establish and communicate clear roles for HEALTH employees, and achieve coordination and integration of	4a. Incident Commanders work with divisions and partners to identify key roles and resources needed for emergency(ies) under their domain.	4a. Key roles and needed resources adopted by June, 2004. 4a. Clear protocols are in place to activate or engage the disaster plan by (date). 4a. A mechanism is in place to deploy human and other resources in a public health emergency by (date).			

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments	Other External Parties
planning with other partners in emergency response (by date).	4b. Proactively communicate with employees and key partners to make sure people understand their roles. Management Services to work with employees to clarify their roles in an emergency e.g. when they are required to work, changes in assignment, issues related to compensation, helping them develop plans for personal needs and dependent care should they be called to work in an emergency. 4c. Develop greater understanding by, and coordination with, local officials (water authorities, municipal gov't and other external partners) regarding their responsibilities in emergency response and about the limitations of state resources to run local infrastructure (e.g, many small water authorities believe the State will take over and run their facilities during emergencies).	4b. People possess and can demonstrate proficiency with relevant materials and equipment by (date). 4b. Ability to respond to when called to work in emergencies, and can perform well in drills and in emergency response situations by (date). 4c. EOP distributed to municipalities for comment. Comments received from at least 10% by (date). 4c. Municipalities invited to participate in all drills. Immediate debriefing ("Hotwash") includes comments from municipalities by (date). 4c. HEALTH's work with cities and towns pass the "mission vision test" by (date). 4c. There is a map, and current list, of whom we mean when we talk about local level coordination – mayors, town managers, schools, police, fire, rescue etc. by (date). 4c. HEALTH staff across divisions are sharing and using contacts with cities and towns efficiently by (date).	4c. Bioterrorism program, Environmental Health		4c. Municipalities, Leagure of Cities and Towns, NACCHO
5. Ensure that internal and external needed skills and resources are in place to support Emergency Response Plan (by date).	5a. Assess resource needs to respond to various emergencies and develop the capacity to 1) assess the training needs, and 2) meet these needs with respect to public health emergencies. 5b. Identify health provider skill sets for public health emergencies. 5c. Provide training or refer to training sources. 5d. Categorize community-based partners by skill set for potential contact in event of emergency. 5e. Maintain and expand outreach with partner laboratories, offer appropriate protocol training and conduct an annual statewide laboratory drill to assess capability.	5a. Internal skills identified and matched with existing staff or training developed by June, 2004. 5a. All staff identified for training are trained by August, 2004 . 5b.Health providers/ community partners skill sets identified and categorized by April, 2004. 5c. Training is implemented by (date). 5d. Categorized lists available to appropriate groups for use in emergency by (date). 5e. Training is held by (date). 5e. Annual drill is carried out 5e. Assessment of drill is made by (date).	5b. OPC Chief, program managers 5d. OPC partners (see 9c.)		
6. Encourage and support the state in the	6a. Address need for a plan for radiation events, ESF8 system, epidemiologic plan re: delivery of	6a. Final Emergency Response Plan published by (date) that includes:	All programs	Governor's office, EMA	

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments	Other External Parties
development of state Emergency Response Plan (by date).	mass health care services.	- a final plan for radiation events - plan for managing the Strategic National Stockpile. - emergency support function (ESF8) system development - epidemiologic response plan that addresses delivery of mass health care services			
7. Ensure a proactive, coordinated response to the threat of infectious disease outbreak and biological acts of terrorism (by date).	7a. Complete CDC/BT Plan 7b. Review plan quarterly and revise as needed. 7c. Maintain laboratory capacity to address bioterrorism, infectious disease outbreak and environmental emergency response. 7d. Develop and maintain the capability of emergency response to an incident of chemical poisoning in the food supply by implementing a food chemistry testing program for analyzing food for the presence of chemicals/poisons. 7e. Create a disease specific epidemiology related operational plan for each of the following: SARS completed 03 Plague by 12/03 Small Pox by 3/04 Botulism by 6/04 Anthrax by 9/04 Category B Agents by 12//04 7f. Augment detection of communicable diseases through epidemiology and laboratory capacity building activities focusing on development of active surveillance systems with licensed laboratories. 7g. Augment detection of communicable diseases	7a. Plan completed by Dec. 2003. 7a. Complete outbreak response manual by December, 2003 7b. Quarterly review schedule is set by (date). 7b. Plan is reviewed on schedule and revised as needed. 7c. Sampling and Lab protocols established by (date) for screening and analyzing food, water, air, soil and dust for suspected contamination incidents in which the agent is unknown. 7c. Protocols, equipment and supplies available to rapidly identify likely bioterrorism agents. (*Already in place*) 7c. Capability in place for analysis of clinical specimens for chemical threat agents by (date). 7d. Plans completed by 12/04. 7d. Capability in place in the Chemistry and Microbiology Labs to test food for agents of Bioterrorism pursuant to the FDA/CDC protocols by February 2004. 7e. f. Audit tools to document lab capacity and progressive improvement will be implemented and monitored by (date). 7e. f Standard CDC guidelines for evaluating surveillance systems from baseline are in place and used as yardstick by (date). 7e. f. Development of surveillance systems completed by 12/05. 7g. Document processes such as trainings, publications, web postings, alerts and advisories etc. by 12/2005.	7a. Epi, Food, Lab 7c. HEALTH lab Other state labs 7e. Health statistics, EH, LAB, DPC 7f. LAB, HSR	7c. DEM 7e. DEM, MHRH	7c. CDC, EPA, ATSDR, Fed Bio-terrorism Partners, Regional Lab Directors Assoc, Private labs 7e. CDC, Brown, Hospital ICP's. 7f. Commercial labs, CDC, NEDSS contractor

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments	Other External Parties
	through activities to increase provider awareness and reporting from all reporting sources as required by regulation.	7g. Maintain and monitor contract with BDEP (Biodefense and Emerging Pathogens Service) at Memorial Hospital by (date).	7g. DPC, CM, CHC, HSR 7g. DPC	7g. DEM, DOC, MHRH	7g. Brown, primary care providers, hospitals, all other health facilities and professionals.
	7h. Develop "special" surveillance systems for detection of BT agents by establishing an electronic syndromic surveillance system for emergency rooms.	7h. Special system in place by 12/2005.	7h. IT, LAB, Statistics, DPC, MS, HSR, EH	7h. Bio-terrorism partners	7h. Brown, hospitals, CDC, other states.
	7i. Conduct a seminar for first responder personnel to train them in their role and explain the roles of the FBI, HAZMAT, DEM, State Fire Marshall, HEALTH Bioterrorism Response Lab and other offices in HEALTH in responding to a suspected act of bioterrorism.	7i. Seminar conducted by June 2004			
8. Develop capacity and schedule drills for response to large scale natural/ man made disasters (hurricanes, power outages, nuclear power plant ingestion pathway incidents, flooding, water contamination issues, oil spills, large outbreaks, food recalls, terrorist events) (by date).	8a. Conduct 'Table Top exercises for disaster drills. 8b. Conduct at least one drill for all defined emergencies within HEALTH by October, 2004. 8c. Conduct at least one drill for all defined emergencies with emergency response partners external to HEALTH by December 2005. 8d. Train personnel in how to conduct "hot wash". 8e. Use natural disasters as emergency response drills. 8f. Use drills to train personnel in epidemiologic investigations, contact tracing, mass prophylaxis, and mass immunizations for all CD's in 7e. 8g. For each drill, conduct appropriate "hot wash" debriefing activities to identify deficiencies. 8h. Assign a single person within HEALTH to develop and write a plan of correction for the	8a - f. Timetables established for drills and drill training by (date). 8a – f. Timetable is adhered to, and related training is conducted by (date). 8g – h. Post mortems completed within (amt of time) of drill and reported to Director. 8g – h. Number of deficiencies and improvements identified from drills.	8a – f. Bio-terrorism, All programs	8a-f. EMA, Bio-terrorism partners, MHRH	8a-f. Partners will be specific to each CD and event – FBI, CDC, EMA

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments	Other External Parties
	deficiency within 1 month of the "post mortem". 8i. Implement hotwash recommendations to address any deficiencies, and to make any changes to improve the EOP.	 8i. Number of improvements made e.g.modifying the EOP, scheduling additional training, acquiring supplies/equipment, etc.			
9. Develop and coordinate plans for program specific response and support communications with key audiences during a public health emergency by date. NOTE: See EOP IV: Organization and Assignment of Responsibilities for planning and response Section A.1-2. Also Annex K-X.) (Also see EOP IV, C and Annex F-Public Affairs Support)	9a. Develop communications plans (technology, systems, personnel) to support program specific responses during a public health emergency (e.g. disease outbreaks, water contamination, mass casualties) 9b. Use the Public Health Information Emergency Response Plan (technology, systems, personnel) to support the receipt, organization and dissemination of public information during an emergency. (Jan '01/revised Jun '03) 9c. Analyze the Public Health Information Emergency Response Plan to insure that plans are in place for reaching non-English speaking, disabled, aged, and difficult to reach communities, and make recommendations to fill any identified gaps.	9a.1 Communications plans (technology, systems, personnel) for each of the program-specific emergency responsibilities in the HEALTH EOP by (date). 9a.2 Analysis of communications technology requirements for IT/Informatics plan (10b) by (date). 9b.1 Conduct drills and evaluate Public Health Information Emergency Response Plan by (date). 9b.2 Use and evaluate plan in actual emergency situations by (date). 9b.3 Revise and update plan as necessary 9b.4 Analysis of communications technology requirements for IT/Informatics plan (10b) by (date). 9c. Analysis complete and recommendations implemented by (date).	9a. Community outreach, All programs, DPC for blast fax 9c. Minority health	9c. OPC partners including but not limited to PCPAC, OHPAC, RIHCA, DEPAC, DOES, DIRES, WCSP MAC, RIMS, RIDA,RIDHA, SNA	9c. Churches, minority based groups, media, hospitals, health centers, SEAC, Progreso Latino
10. Use data and technology to support and enhance the capabilities of the Emergency Response Plan by (date).	10a. Use Geographic Information System (GIS) technology to develop maps crucial for rapid emergency response. 10b. Develop a communications technology plan to implement the infrastructure required by	10a. Maps developed that show water supplies, water distribution systems, health care facilities, emergency shelters, flooding and slosh maps for hurricane response, all food establishments identified by type, fuel tanks, wastewater treatment facilities and combined sewer overflows, sources of ice and dry ice, farms, police, fire and other emergency response information by (date). 10b.1 Communication technology/Informatics plan to address multi-technology needs of individual emergency response	10a. IS, Program Offices		

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments	Other External Parties
	operational communications and public health information functions during an emergency (See EOP Section IV.D.1.c and Annex H-6 IT/Communications Support)	operational plans and public information plan, including (but not limited to) • blast fax/email/phone/pager capabilities by (date). • database directory of contacts (dept-wide) by (date). • Nextel, radio voice/data systems by (date). • Public health and law enforcement linkages by (date). • Electronic exchange of clinical, lab, environmental and pub health data by (date). • Municipal, hospital, laboratory data networks by (date). • HEALTH Intranet by (date). • Wireless voice, data, Internet technology by (date). • Interactive web forms and query systems by (date). • Secure, redundant communications technology by (date).			

Goal #3 Use public health data and science to guide policy and program development, implementation, evaluation and retention. Position HEALTH as the key source of public health information, and provide easy access to high quality public health information that people want and need by 2009.

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments/ Partners	Other External Partners
1. Establish and implement Department-wide standards for statistical methods and programming tools for data collection, analysis, and dissemination by (date).	1a. Adopt and attain data management standards across all key HEALTH databases.	1a. Number of databases meeting data management standards by (date).	All	1a. Cities and Towns	
	1b. Develop and implement regular trainings for HEALTH program directors and staff to support database use and understanding of databased programming, planning and evaluation.	1b. Number of staff trained by (date).	All	1b. DEM, DHS, DEA, DBR, MHRH, DOE, AG	1b.Licensed Professionals, Facilities, Professional and Business Associations Brown, URI, funding sources
	1c. Enhance HEALTH's capacity to analyze and apply health quantitative data by coordinating resources.	1c. Department-wide implementation of the HEALTH GIS infrastructure completed by (date).	All	1c.DoA (RIGIS), DEM, DoT, URI, RIEMA.	
		1c. Public health applications of GIS adopted by all appropriate HEALTH programs by (date)	All		
		1c. Resources are coordinated and appropriate by (date).	All	1c. RIEMA	1c. CDC (BT), Providence Plan, HARI
2. Utilize public health science to guide policy and program development, implementation, evaluation and retention (by date).	2a. Provide opportunities for HEALTH personnel to have a foundation of public health sciences	2a. Number of HEALTH personnel involved in continuing or advanced Public Health training opportunities by (date).	All		
	2b. Routinely involve internal and external professionals versed in the collection, analysis, and interpretation of public health data in the development of state health policy and program management functions.	2b. Number of policies developed with support from data professionals and other public health science professionals by (date).	All		
		2b. Number of programs with management functions developed with support from data professionals by (date).	All		
	2c. Assure that proven-effective or evidence-based practices are employed in the delivery of public health services as	2c. HEALTH services are modeled after evidence-based strategies by (date).	All		

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments/ Partners	Other External Partners
	appropriate				
	2d. Explore and evaluate promising intervention strategies that are based on clear logic models.	2d. Innovative approaches to public health services are undertaken and evaluated by (date).	All		
	2e. Design and implement evaluation plans for all HEALTH interventions.	2e. Number of evaluation plans implemented by (date).	All		
3. Establish HEALTH as the key source of public health information by (date)	3a.Determine what data/information and dissemination strategies our customers and partners need and want.	3a. Assessment completed, analyzed and implemented by (date).	All		
	3b. Disseminate information and data to our customers and partners using strategies (e.g. media, print, blast fax, website) that best meet the needs of the intended audience.	3b. Number of communications strategies matched to appropriate audiences by (date). 3b. Communications schedule established and implemented by (date).	All		
	3c. Prepare and disseminate periodic summaries (e.g. annual reports) for every database that contains information on significant health outcomes on the population of Rhode Island or major population components.	3c. Number of annual reports prepared and disseminated by (date).	All		
	3d. Utilize HEALTH website to disseminate user-friendly, timely, and relevant data and information and to reinforce information disseminated through alternative strategies.	3d. Number of data sets available on a timely basis through web query systems by (date). 3d. Health information updated according to review schedules by (date) 3d. Number of website "hits" by (date).	All All 3d. CHIC	3d.DEM, DOT, DOA, DHS, DOC, DCYF, DOE, MHRH	3d.Colleges and Universities, Providence Plan, CBOs, cities and towns
4. Upgrade, integrate, maintain and apply information and computer technology approaches in HEALTH services by (date)	4a. Complete the Public Health Informatics Strategic Plan, and make recommendations to the Exec. Comm. relative to ways to improve, integrate and maintain HEALTH's databases.	4a. PHI Strategic Plan submitted and approved by EC by (date) 4a. Recommendations implemented by (date)	All		4a.CBO's, cities and towns
	4b. Establish formal process to prioritize database and data systems for upgrading,	4b Process in place for establishing priorities and priorities evaluated and set			

Objectives	Action Steps	Measures	Internal Partners/ Responsible Parties	External Departments/ Partners	Other External Partners
	integration, and maintenance.	periodically by (date).			
	4 c. Expand VR 2000 to include the death, fetal death and marriage modules	4c. Modules implemented by (date)		4c.DEM, DOT, DOA, AG, DHS, DLT, DOC, DBR, DCYF, DOE, Gov, etc	4c.CBO's, cities and towns, health care facilities, researchers, etc
	4d. Enhance License 2000 to be the depository of all germane information (e.g., complaints, worksite, race and ethnicity, etc.) related to licensed entities	4d. License 2000 fully operational by (date)	4d. HSR	4d.DEM, DOT, DOA, DHS, DOC, DCYF, DOE, MHRH	
	4e. Acquire and maintain appropriate hardware, software and connectivity and train staff to use them (e.g. GIS).	4e. Hardware, software and connectivity fits within existing infrastructure by (date)			
		4e. Training sessions provided to HEALTH staff by (date).			
5. Assure, maintain and improve quality public health data and information by (date)	5a. Design and implement quality assurance plans for every HEALTH data set.	5a. Number of quality assurance plans implemented (by date).	All		
	5b. Inventory existing databases and evaluate for accuracy, redundancy, gaps and opportunities for collaboration and quality improvement. (e.g. License 2000)	5b. Inventory conducted and evaluation done by (date).	All		

Goal #4: Develop and implement a public health agenda and plan for healthy homes and healthy communities in Rhode Island core cities by 2006 and for the entire state by 2008.

Objectives	Action Steps	Measures	Internal Partners / Responsible Parties	Other Departments	Other External Partners
1. Determine HEALTH's roles and responsibilities and select priority indicators for healthy homes and healthy communities by (date).	1a. Convene a workgroup of internal and external partners to identify indicators of a healthy home and healthy community. 1b. Identify/define parameters for healthy homes and communities (via search of scientific literature, current national and RI standards, and major causes of morbidity and mortality in RI. 1c. Select priorities from indicators for healthy homes and healthy communities.	1a. List of indicators developed by (date) and are maintained. 1b. Data inventory complete by (date). 1c. RI priorities established by (date). Community profiles developed by (date). Data maps available in web by (date).	ALL	1. DEM, DCYF, DOE, DEA, State Building Official, State Fire Marshall, Police, DHS AG, RI Housing, DOA – Energy Assistance Office, Housing Resources Commission	2. Providence Plan, municipalities, Census, Chief elected officials, building officials, RI Housing, local housing office (if any), minority organizations, Childhood Lead Action Project, City and town housing authorities, lead hazard reduction programs, CDC, HUD, Insurance Companies (Home Owners), Realtors, RI Legal Services, Supermarkets, Food Dealers Association, Liquor stores (are there groups that represent them?), YMCA and other groups engaged in promoting physical activity, Neighborhood associations, CATCH Planning groups, Brown, URI, Architecture schools.
2. Gather and analyze indicator data for healthy homes and healthy communities for core communities by (date) and for entire state by (date).	2a. Workgroup to review or inventory HEALTH's mandates/regulations/ standards/guidelines /recommendations with respect to the indicators that are established. 2b. Workgroup to inventory current HEALTH programs and existing data that relate to healthy homes and healthy communities by June, 2003, and identify gaps. 2c. Workgroup to review existing state housing programs and state community planning programs for gaps – develop HEALTH response where applicable. 2d.Develop plans for obtaining the data HEALTH needs to assess priority indicators by (date). Collect and analyze these data by (date).	2a and b. All offices have responded re: current activity in healthy homes / communities. 2a - d. Inventories and needs assessment completed by offices and workgroup by (date). 2a. – d. Core communities identified by (date).	2. ALL	2. DEM, DCYF, DOE, DEA, State Building Official, State Fire Marshall, Police, RIGIS (DOA), DOT	2. Chief elected officials, building officials, local housing office (if any), minority organizations
3. Establish cross-divisional support teams to work with core cities to develop and implement a plan that addresses the priorities for each core city by (date) and for the entire state by (date).	3a. Identify external partners that share/have responsibility for healthy communities in conjunction with HEALTH (community mapping). Establish contacts at the city and town levels, and develop a program in partnership with cities and towns. (For example, a program for control/management of pest-borne illness and infestation 3b. Identify which division/ programs impact in the issue and create "support group" with clearly identified "lead" person by issue.	3a.Partners identified by (date). 3a. Community mapping completed by (date). 3a and b. Cross-functional support teams established by EC by (date). 3b. Lead person identified by (date).	3. ALL	3. DEM, DCYF, DOE, DEA, State Building Official, State Fire Marshall, Police, Cities and towns, state agencies, CBO's, Dept of Corrections	3. Chief elected officials, building officials, local housing office (if any), minority organizations

Goal 5: Develop and implement a public health agenda and plan for healthy human development for Rhode Island, connecting physical, educational, cultural, emotional, social and economic environments to health outcomes by 2006.

Objectives	Action Steps	Measures	Internal partners / Responsible Parties	External Departments	Other External Parties
1. Adopt a framework in HEALTH for human development through the lifespan by (date).	1a. Identify the internal and external experts and stakeholders for human development and assess their roles. 1b. Convene internal and external partners and experts to articulate human development as a key determinant of health. 1c. Review scientific literature and models from other locations to identify parameters for healthy human development. 1d. Identify the RI public health priorities that are connected to human development. 1e. Promote the model to all HEALTH employees and provide training. 1f. Maintain and update the model regularly.	1a. and b. Work group convened with appropriate representation by (date). 1c. Literature review and findings from other jurisdictions completed by (date). 1d. Priorities identified by (date). 1e. Training completed by (date). 1f. HEALTH conceptual model established and maintained by (date).	ALL	DOE, DHS, DLT, DOC, DCYF, Dept of Elderly Affairs, MHRH, URI, RIC, Brown	
2. Identify periods of opportunities and vulnerabilities along the human development continuum, connecting physical, educational, cultural, emotional, social and economic environments to health outcomes by (date).	2a. Identify the major causes of RI mortality and morbidity, and define the health risk factors and outcomes that are most amenable to a developmental approach. 2b. Identify key contributors to the major causes of RI mortality and morbidity (e.g. physical, educational, cultural, emotional, social and economic, etc. factors that contribute to obesity). 2c. Assess health influences by specific populations and focus on populations presenting particular	2a. List of major causes of RI mortality and morbidity by (date). 2b. List of underlying factors developed by (date). 2c. Target populations and health threats identified by	ALL	2a. Other state agencies, CBO's 2b. DOE, DHS, DLT, DOC, DCYF, Dept of Elderly Affairs, MHRH, URI, RIC	Parents, educators, neuroscientists, RI Kids Count, Superintendents Association Principals Association School Committees RI Parent Teacher Association Early Intervention Providers Brown University Topical Partners e.g. Physical activity/Nutrition Health care providers Groups serving special populations.

Objectives	Action Steps	Measures	Internal partners / Responsible Parties	External Departments	Other External Parties
	developmental opportunities and/or vulnerabilities (e.g., infancy, elders in care, etc.).	(date).			
3. Identify and implement policies and programs that promote healthy human development and address the impact of physical, educational, cultural, emotional, social and economic environments on health outcomes by (date).	3a. Identify opportunities for interventions (eg. Long-term care facilities transitioning, immunizations), including policies, that will have the most impact on public health priorities, considering community development, theoretical models (e.g., Prochaska), racial, gender, sexual orientation, and class issues as they relate to human development and the physical, educational, cultural, emotional, social and economic environments. 3b. Determine the role, including investments that each division/program plays in human development and the physical educational, cultural, emotional, social and economic environments. 3c. Evaluate effectiveness and comprehensiveness of current external/internal roles. Identify gaps in responsibility for human development initiatives. 3d. Coordinate and collaborate with internal and external partners to seize opportunities to implement interventions. 3e. Establish, implement and evaluate work plans, lead responsibility, data systems and process measures.	3a. b. and c. Reponses from each office on current activities by (date). 3a.b. and c. Self-evaluation and identification of gaps as part of survey by (date). 3d. and e. Work plan and measures developed by (date). 3d. and e. Assignments made by (date). 3d. and e. Implementation with tracking of successes and progress begins by (date).	ALL	3. DOE, DHS, DLT, DOC, DCYF, Dept of Elderly Affairs, MHRH, URI, RIC, State Building Official, Fire Marshall, and Police	RI Kids Count Superintendents Association Principals Association School Committees RI Parent Teacher Association RI Commission on Women Early Intervention Providers Brown University, minority organizations, Topical Partners e.g. Physical activity/Nutrition Health care providers, schools, town officials, groups serving specific populations

Goal 6: Promote ongoing improvement in the quality of health care services and assure compliance with standards for health care services.

Objectives	Action Steps	Measures	Internal Partners	External Departments	Other partners
1. Ensure establishment of and compliance with effective rules and regulations to set prevailing standards for health care services.	1a. Identify current HEALTH activities to assure compliance with health care statutes and regulations by (date). 1b. Review other state, federal, and national organizations assure compliance by (date), and recommend needed statutory and/or regulatory changes by (date). 1c. Reference relevant national accreditation agencies and evaluate the significance, cost effectiveness, and viability of adopting national standards to support quality improvement by (date). 1d. Identify cost-effective technologies (e.g., computer software) to improve internal efficiency of operation and to monitor compliance with standards by (date). 1e. Schedule regular reviews and updates of existing rules and regulations by (date). 1f. Require and recognize national accreditation through health care facility licensure process (initial licensure, certificate of need, change in effective control) and the development of regulations, whenever appropriate by (date). 1g. Adopt standards for cultural and linguistic competence of health care providers and institutions by (date). 1e. Improve quality of health care services through the public licensure process by (date). 1f. Retrieve, compile, analyze, and follow up on medical error data by (date). 1g. Monitor the impact that health plan, utilization review activity has on quality, continuity and access to care by (date). 1h. Establish an immediate (24 hour) response system for significant medical error reporting and disposition by (date). 1i. Appropriately survey/inspect entities (e.g. insurers, utilization review agencies, health care facilities, providers) by (date).	1b. Statutory and/or regulatory changes recommended. 1c. Recommendation re: accreditation completed. 1e. Regulation review schedule 1i. Mandated or recommended frequency for each type of inspection is determined. 1f. Report on medical error data . 1g. Report on impact of UR. 1h. Medical error reporting system in place	ALL, Boards for health care professions	AG, DHS, DEA, DBR, General Assembly, Gov Office, DOA,	Quality Partners RI, RI Medical Society VNA, RI Health Center Association HARI, IHI, RI Quality Institute, providers, NCQA, JCAHO, ASTHO, Other state health departments, NACHO, APHA Health Care Quality Forum, consumers QPRI, VNA, RIHCA, RI QUALITY INSTITUTE, HC QUALITY FORUM, Insurers, Medicare, Licensed health care providers and facilities, RI Medical Society
2. Promote evidence-based clinical performance and other quality improvement	2a. Assess current non-regulatory quality improvement activities, major problems, evaluate effectiveness and comprehensiveness, and determine gaps by (date).	2a. Inventory of non regulatory HEALTH QI activities completed			

Objectives	Action Steps	Measures	Internal Partners	External Departments	Other partners
activities.	2b. Reference relevant national accreditation agencies and evaluate the efficacy of national standards to support quality improvement efforts by (date). 2c. Identify which national priority quality improvement areas to promote evidence based clinical performance guidelines and other quality improvement activities are priorities for HEALTH by (date). 2d. Educate providers on priority guidelines to assure on-going improvements by (date). 2e. Identify HEALTH clinical databases used for quality improvement, and coordinate, identify gaps and improve accuracy and comprehensiveness by (date). 2f. Benchmark RI health care performance against evidence-based clinical guidelines and regulatory/ statutory standards by (date). 2g. Coordinate internal non-regulatory quality improvement efforts in health care institutions by (date).	2d. Training materials developed 2e. Inventory of data sets completed 2e. Biennial public reports on clinical performance standards published 2f. Overlap of internal QI efforts with RI health care institutions/providers identified			
3. Facilitate processes for consumers to hold providers accountable for quality.	3a. Provide up-to-date and culturally-relevant information (i.e. health care facility and physician profiles and other health professions, performance measurement reports, and other public reports) through multiple appropriate communication channels, by (date). 3b. Solicit and incorporate consumer feedback on information and products supplied by HEALTH. 3c. Disseminate evidence-based best clinical performance guidelines to providers and consumers through multiple appropriate communication channels by (date). 3c. Utilize a unified structure/process/timeline for complaint receipt, monitoring and result determination by (date). 3d. Provide public access to health statistical indices (e.g., tertiary care reporting) and national sources/references (national, regional, statewide & local comparisons), benchmark measures, and best practice approaches, etc. for consumer use and research on quality of care issues by (date).	3a & b. Communications channels established	HSR EH CM DPC LAB DFH CHIC, Legal Boards for health care professions, CHIC, HSR, ALL	DEA DHS AG	Health care providers Quality Partners RI, VNA, RI Health Center Association HARI, IHI, RI Quality Institute, Health Care Quality Forum, Community attorneys, RI Medical Society, Insurers, Brown University, RI Quality Partners, Subspecialty Physician Groups, RI Health Center Assn, health care providers and facilities, LTCC Professional Assns
4. Improve the accessibility of health care services.	4a. Articulate HEALTH's role in increasing access to health care including availability of providers, insurance coverage, utilization of federal entitlement programs by (date).		HSR DFH DPC	DHS MHRH DEA	

Objectives	Action Steps	Measures	Internal Partners	External Departments	Other partners
	4b. Align health care service investments (e.g. WCSP) for uninsured and other specific populations by (date). 4c. Assure cultural and linguistic diversity in HEALTH's health care service investments. 4d. Assure adherence to certificate of need and charity care regulatory provisions by (date). 4e. Evaluate geographical access of providers and institutions care by (date). 4f. Standardize the collection of data to evaluate the impact of programs assuring access to health care by (date). 4g. Systematically monitor and act on access-related complaints by (date). 4h. Enact statutory requirements for cultural and linguistic competence of health care providers and institutions by (date).		CHIC HQPM CM	DOA AG DLT DBR	

Goal 7: Assess and build the capacity of provide essential public health services for the people of Rhode Island by 2009, using National Public Health Performance Standards.

Objectives	Action Steps	Measures	Internal Partners	External Partners	Other Partners
1. Promote the 10 essential public health services as model for an effective public health system in Rhode Island by (date). (See Appendix A attached – *The Ten Essential Health Services)*	1a. Identify and train key HEALTH staff from each Division who will be responsible for training all HEALTH staff. 1b. Determine and provide appropriate level of training for all HEALTH employees. 1c. Provide training to external partners in the public health system such as policymakers and legislative staff.	1a. All HEALTH employees know and understand essential public health services (by date). 1b. Employees trained (by date). 1c. Partners have access to training opportunities (by date).	ALL	ALL	All HEALTH partners
2. Coordinate the assessment of the public health system using the National Public Health Performance Standards by (date).	2a. Identify and train a team on National Public Health Performance Standards including the administration of the assessment. 2b. Obtain cross-divisional and external input regarding administration of the assessment by. 2c. Implement the assessment of the Rhode Island public health system and forward results to CDC for analysis. 2d. Collect evaluative feedback on process and tool and forward to CDC.	2a. Team identified and training completed by (date) 2b. Partners identified and input collected (by date). 2c. Plan for assessment in place and assessment completed (by date). 2d. Feedback provided to CDC (by date).	ALL	ALL	All partners in public health system as determined by the group
3. Build the capacity of the public health system using results from the assessment by (date).	3a. Analyze and disseminate the results. 3b.Prioritize areas where the capacity of the public health system must be enhanced based on the public health priorities in Rhode Island. 3c. Provide leadership and work with community partners to develop, implement, and evaluate a plan to enhance priority public health system areas. Plan will include building resources in state and federal budget, funding partnerships, staffing, etc. 3d. Establish schedule and implement periodic reassessment of public health system capacity. 3e. Upon completion of full cycle, collect feedback on process and tool and forward to CDC.	3a. Results disseminated (by date). 3b and c. Quality improvements in the provision of public health services (by date). 3d. Schedule complete and periodic assessment complete as scheduled (by date). 3e. Feedback provided to CDC (by date)	3a. Team 3b. EC, Team 3c. Team, All	ALL	All partners in public health system as determined priorities

Goal 8: Engage the entire health sector and other partners in preventing and controlling infectious disease by 2005.

Objectives	Action Steps	Measures	Internal Partners	External Partners	Other Partners
1. Coordinate internal resources and increase collaboration among HEALTH divisions and external partners that have a role in the prevention and control of infectious disease by (date). [Ref Goal 1]	1a. Identify internal partners and assess current engagements with health care sector and other sectors. 1b. Identify existing programs, personnel, venues, coalitions and products that are active in prevention and control 1c. Consolidate duplicative efforts and share resources and coordinate programs to more effectively prevent and control infectious disease.	1c. Number of efforts that result in streamlining by (date).	All divisions, offices and programs	CDC, MHRH, DEM, DCYF, DHS	HARI, Laboratories, licensed practitioners, community health centers, VNA, Media HMO, Community Coalitions (disease specific)
2. Identify and engage partners in infectious disease prevention, surveillance and control and determine their role by (date).	2a.. Engage the medical community in infectious disease reporting. Identify and employ multiple strategies to build two-way communication with providers on this issue. 2b. In cooperation with partners, assess responsibilities for infectious disease prevention and control and modify as needed. 2c. Identify new opportunities to leverage existing relationships with health and other sectors. 2d. Look at best practices nationally Determine what other states are doing appropriate to our needs. (i.e. quality assurance) 2e. Provide technical assistance and training to partners to help them fulfill their roles. 2f. Design health promotion interventions to prevent and control the spread of infectious disease (e.g. hand washing, responsible sexual behavior, immunization, etc.)	2a.Disease reporting increases by (date). 2b. Assessment and evaluation completed by (date). 2e. Training and technical assistance offered and utilized by (date).	All	2b. Other state agencies, health care facilities, providers, cities and towns, CBO's.	Health care partners in the community (health centers, hospitals, individual practitioners) Other states and CDC

Objectives	Action Steps	Measures	Internal Partners	External Partners	Other Partners
	2g. Develop capacity within Local Emergency Planning Committees (LEPCs) for completion and implementation of infectious disease control plans.	2g. All LEPCs have workable plan by (date)s.	2g. DPC, CHIC, DFH	2g. DOE	2g. Schools, health care providers, hospitals, Policy Studies, Inc.
3. Develop an infectious disease reporting system to rapidly identify and respond to potential outbreaks.	3a. Identify symptoms of interest. 3b. Enhance current surveillance data system to capture these data. 3c. Pilot syndromic reporting system either with a small number of providers (sentinel docs?) or for a specific problem (e.g., info request on Conimicut)	3a - c. Surveillance capability established and tested by (date).	DPC, DFH, LABS, EH, CM		
4. Implement infection control guidelines in healthcare settings and congregate settings (prison, schools etc) by (date).	4a. Identify appropriate standards, training, and equipment in all facilities to insure worker safety. 4b. Ensure compliance with the requirements identified in 1a (e.g., blood-borne pathogen requirements) in all facilities.	4a and b. Number of violations decreased by (date).			

Appendix A – The Ten Essential Health Services

The Essential Public Health Services

The **Essential Public Health Services** provide the fundamental framework for the NPHPSP instruments, by describing the public health activities that should be undertaken in all communities. The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate, and empower** people about health issues.
4. **Mobilize** community partnerships and action to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Assure** competent public and personal health care workforce.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.